U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 12 June 2007

In the Matter of

J.E.F.[1]
Claimant

Case No.: 2006 BLA 10

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. William Turner, Attorney
For Claimant

Ms. Kathy Snyder, Attorney
For the Employer

Mr. Ronald Gurka, Attorney (on brief)
For the Director

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER --
DENIAL OF BENEFITS

This matter involves a claim filed by Mr. J.E.F. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725.[2] Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who

[1]Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

[2]In January 2001, the U.S. Department issued major revisions to Parts 718 and 725. The provisions of the revised regulations applicable to Mr. F. claim are designated with the suffix "(2001)."

died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim
(DX 1)[3]

Mr. F. filed his first claim for black lung disability benefits on August 5, 1997, while still working as a coal miner. After a pulmonary evaluation, a claims examiner for the U.S. Department of Labor ("DOL") denied his claim for benefits on January 7, 1998. An exercise blood gas study met the total disability standards. However, since the preponderance of the radiographic evidence was negative for pneumoconiosis, the claim was denied.

Present Claim

Initial Adjudication

On September 30, 1999, Mr. F. filed his second claim for benefits (DX 2). In early December 2000, the District Director rendered an initial determination that Mr. F. was entitled to black lung disability benefits and sent notices to several potential responsible operators, including Westmoreland Coal Company ("Westmoreland") (DX 23, DX 25 to DX 31). On December 12, 2000, Westmoreland contested its designation as the responsible operator and Mr. F.'s entitlement to benefits (DX 34). On December 29, 2000, since additional investigation into the designation of the proper responsible operator was necessary, the District Director initiated interim benefits (DX 36). On April 15, 2003, after naming three potential responsible operators, the District Director forwarded the case to the Office of Administrative Law Judges ("OALJ") (DX 54 to DX 56)

On November 9, 2004, after two continuances and a hearing on October 19, 2004, Administrative Law Judge Michal Lesniak remanded the case to the District Director to address several issues relating to the designation of the responsible operator (DX 81).

On October 21, 2005, after re-assessing the responsible operator issue, the District Director returned the case to OALJ (DX 89).

Pursuant to a Notice of Hearing, dated January 26, 2006 (ALJ I), I conducted a hearing on April 20, 2006 in Beckley, West Virginia with Mr. F., Mr. Turner, and Ms. Snyder. A representative for the Director did not attend.

Evidentiary Discussion

At the April 2006 hearing, I added to the record the transcript of Administrative Law Judge Michael Lesniak's October 19, 2004 hearing in this case as DX 92.

[3]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

As I previously approved (TR, p.32), I received post-hearing a supplemental report by Dr. Fino and Dr. Rasmussen's deposition. These documents are admitted as EX 8 and EX 9.[4] Accordingly, my decision in the case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 92, CX 1, and EX 1 to EX 9.

ISSUES

1. Responsible operator.

2. Whether in filing a duplicate claim in September 1999, Mr. F. has established a material change in conditions since the denial of his most recent prior claim in January 1998.

3 If Mr. F. establishes a material change in conditions, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the April 20, 2006 hearing, the parties stipulated that Mr. F. was a post-1969 coal miner and Mrs. S.F. is a dependent for the purpose of augmenting any benefits that may be payable under the Act. (TR, p.8 and 36).

Preliminary Findings
(DX 1, DX 7, DX 92, and TR, p.36-52)

Born on November 25, 1939, Mr. F. married Mrs. S.F. on December 17, 1966. He started mining coal in 1968. Over the course of 31 years in coal mining, Mr. F. worked as a shot firer, shuttle car operator, miner operator, belt man, section boss, fire boss, and mine foreman. In his last coal mine job as a mine foreman, Mr. F. helped keep the belt system operating which required heavy labor associated with cleaning and changing the belts and rock dusting. In October 1998, while operating a scoop, Mr. F. ran over a timber and jammed his head into the tunnel ceiling. The resulting neck injury caused him to stop mining coal on January 29, 1999. Mr. F. started smoking cigarettes in 1965 at the rate of half a pack a day. He continues to smoke cigarettes at about the same rate; however, for a ten year period, Mr. F. smoked a pack of cigarettes a day.

[4]Although Employer's counsel labeled the report and deposition as EX 5 and EX 6, those exhibit numbers were already used for evidence presented by the employer at the hearing.

Issue # 1 – Responsible Operator

Parties' Positions

Employer

Westmoreland should be dismissed as the responsible operator for several reasons.

First, after Mr. F. filed his present claim, the District Director named Essential Fuels, Inc. ("Essential Fuels"), as insured by the West Virginia CWP Fund ("WVCWPF"), as the responsible operator. Mr. F.'s entitlement to black lung disability benefits was initially contested by counsel for the WVCWPF. However, following the Initial Determination of Benefits, dated November 22, 2000, Essential Fuels and the WVCWPF did not contest the finding of liability within 30 days. As a result, under 20 C.F.R. § 725.419(d), Essential Fuels and its insurer, the WVCWPF, are liable as a matter of law. Since the District Director eventually dismissed Essential Fuels and the WVCWPF, as a potential responsible operator/insurer, the Black Lung Trust Fund becomes liable for the payment of Mr. F.'s black lung disability benefits.

Second, the District Director failed to diligently establish the appropriate responsible operator. Although the District Director had the case for over three years, Judge Lesniak nevertheless determined a remand was necessary for further investigation. Eventually, the District Director sent letters to several corporate officers of various bankrupt companies concerning their personal liability for Mr. F.'s claim. However, no further follow-up was accomplished. Additionally, even though Mr. F. testified at Judge Lesniak's hearing that Essential Fuels and Mate Creek Loading, Inc. ("Mate Creek") were operating in the same mine by the same owner, the District Director released Essential Fuels as potential responsible operator and did not determine whether the common owner, who may have subsequently conducted mining operations in Alabama, has assets available to cover liability. The District Director's failure to diligently investigate the responsible operator issue and pursue potentially fiscally viable corporate officers has prejudiced Westmoreland and warrants holding the Black Lung Trust Fund liable for the payment of Mr. F.'s benefits.

Third, since the District Director permitted Maben Energy, Inc. ("Maben Energy") and East Gulf Fuel, Inc. ("East Gulf"), to self-insure their mining operations, the Black Lung Trust Fund rather than Westmoreland should bear the risk of permitting these two corporations to self insure when they later went bankrupt. Significantly, the Department of Labor recognized this concern in publishing the new regulation provision, 20 C.F.R. § 725.495(a)(4), which transfers liability to the Black Lung Trust Fund when a self-insured corporation goes bankrupt. Although the Department of Labor asserts the new provision applies only to claims filed after January 19, 2001, Westmoreland should not be held liable for the District Director's "misplaced trust" in permitting Maben Energy and East Gulf to self-insure their black lung claims liability.

Director

For several reasons, Westmoreland is the appropriate responsible operator.

First, Mr. F.'s testimony, pay records, and Social Security Administration record establish that between 1997 and 1999, he worked for Mate Creek and not Essential Fuels. Additionally, the two companies were distinct corporate entities. As a result, the insurance provided by the WVCWPF to Essential Fuels did not extend to Mate Creek.

Second, the November 22, 2000 Initial Determination letter gave Essential Fuels and its insurer, the WVCWPF 30 days to accept liability, initiate payments, and return forms indicating their acceptance. The letter explained that in the event no action was taken within 30 days, the claim would be forwarded to OALJ for a hearing. Additionally, since the correspondence was not a proposed decision and order finally resolving the claim and indicated that the claim would be forwarded for a hearing, 20 C.F.R.§ 725.419(d) is inapplicable. Consequently, the inaction by Essential Fuels and the WVCWPF did not establish their liability as a matter of law.

Third, Mate Creek, Maben Energy, and East Gulf can not be responsible operators since they are not capable of paying continuing black lung disability benefits payments.

Fourth, under recognized case law, the District Director is not obligated to pursue corporate officers as responsible operators.

Fifth, Westmoreland is the most recent coal mine operator to employ Mr. F. as coal miner for a cumulative total of more than one year that meets all the criteria for responsible operator.

Additional Findings[5]
(TR, p.36-52, DX 1, DX 25, DX 26, DX 27, DX 49, DX 52, DX 84 to DX 87, and DX 92)

From 1978 for about seventeen months, Mr. F. worked for Westmoreland at the coal mine located at East Gulf. With Westmoreland, Mr. F. earned $17,700 in 1978 and $22,035 in 1979.[6] Westmoreland is a self-insured coal mine operator.

Next, in the same mine, Mr. F. worked for Maben Energy/East Gulf/Maben Energy, owned by Mr. Paul Kizer, for sixteen years from about 1981 to 1997. The company was permitted to self-insure its liability for black lung claims. Towards the end of that employment, the Maben Energy mine ran out of coal. In 1997, Maben Energy and East Gulf, subsidiaries of Adventure Resources, went bankrupt. In February 2005, a Notice of Mr. F.'s claim and a July

[5]I rendered these findings in part based on Mr. F.'s credible hearing testimony and his Social Security Administration records (DX5).

[6]According to the Coal Mine (BLBA) Procedure Manual, the average earnings for a coal miner for one year of coal mine employment (125 days) in 1978 and 1979 were $10,038 and $10,878. Since Mr. F.'s annual wages from Westmoreland Coal Company in those two years greatly exceeded the yearly averages, I specifically find that Mr. F. worked for Westmoreland for more than one year as a coal miner.

2005 Proposed Decision and Order were sent certified mail to Mr. Paul Kizer's last known address and were later returned as undeliverable.

After Maben Energy went bankrupt in 1997, Mr. F. remained the mine foreman when Mate Creek took over the mine. Mate Creek was owned by two brothers, Mr. Tim McCoy and Mr. Dwight McCoy. At the time of the 1997 transition, Mr. F.'s paycheck changed from Maben Energy to Mate Creek. Mr. F. worked as a mine foreman for Mate Creek another 16 months until he left coal mining on January 21, 1999 due to an injury. On the other side of the mountain, Essential Fuels, also owned by Mr. Tim McCoy and Mr. Dwight McCoy, was mining coal in three mines. Since the Mate Creek mine had run out of coal, Mr. F. supervised four men who kept the Mate Creek belt system operating in order that the coal from Essential Fuels' mines could be transported through the mountain to the tipple owned by Mate Creek. Mr. F. explained that coal from the three Essential Fuels mines above the mountain tunnel ran "all the way down the holler and come through our mine to the tipple." Since the operations between Essential Fuels and Mate Creek were related, most people, including Mr. F. when he submitted his black lung claim, considered the arrangement as Essential Fuels. Nevertheless, Mr. F was employed by Mate Creek and his paychecks came from Mate Creek. During this period, Mate Creek was not insured for black lung disability benefits. On May 5, 2000, the corporation of Mate Creek terminated. The December 2000 Notice of Claim addressed to Mate Creek was returned as undeliverable. A February 2003 Notice of Claim, a February 2005 Notice of Claim, a May 2005 Notice of Claim (at a different address), and July 2005 Proposed Decision and Order were sent to Mr. Tim McCoy; the latter three letters were returned as undeliverable.

Discussion

I first conclude the WVCWPF is not liable as a matter of law. As correctly noted by counsel for the District Director, the November 22, 2000 notice to Essential Fuels and WVCWPF did not require any action in the event they did not accept liability. Instead, the letter indicated that Mr. F.'s claim would be forwarded to OALJ within 30 days unless Essential Fuels and the WVCWPF took affirmative action to accept liability.

Secondly, the inequity associated with holding an earlier employer liable as the responsible operator in the event that a more recent self-insured responsible operator goes bankrupt has been acknowledged in the changes to the new regulations under 20 C.F.R. § 725.495(a)(4). However, Mr. F.'s claim predates the effective date of that regulatory change and I have no authority to apply that regulatory relief retroactively.

Turning to the determination of responsible operator in this case, under the regulations, liability for benefits under the Act is assessed against the most recent coal mine operator which meets the requirements set out in 20 C.F.R. §§ 725.492 and 725.493. In light of these requirements, the responsible operator analysis starts with the most recent employer and works backwards in time until the first operator that meets all the regulatory requirements is identified. *See Cole v. East Kentucky Collieries*, 20 B.L.R. 1-51 (1996); *Director, OWCP v. Trace Fork Coal Co. [Matney]*, 67 F.3d 503 (4th Cir. 1995), *rev'g in part sub nom*. *Matney v. Trace Fork Coal Co*., 17 B.L.R. 1-145 (1993).

While the regulatory provisions establish numerous criteria for the designation of a responsible operator, the two relevant requirements for Mr. F.'s claim are length of employment and ability to pay. According to 20 C.F.R. § 725.493(a)(1), the necessary length of employment is a cumulative employment period of more than one year. The second relevant prerequisite for the designation of responsible operator is the ability to pay for black lung disability benefits. Under 20 C.F.R.§ 725.492(a)(4), a coal mine operator may ensure the capability to assume liability in three way: self-insurance, an insurance policy, or possession of assets sufficient to cover its liability. With these two key requirements in mind, I apply the responsible operator analysis in turn to Mate Creek, Maben Energy/East Gulf, and Westmoreland.

Mate Creek

I find Mr. F. worked more than one year as a coal miner with Mate Creek.

However, the record demonstrates that Mate Creek was not insured for black lung claims and terminated as a corporation in May 2000. Additionally, the Notice of Claim to Mate Creek was returned as undeliverable. Consequently, I find Mate Creek does not have the capacity to pay continuing black lung disability benefits.

Turning to consideration of whether Mate Creek's corporate officers, specifically Mr. Tim McCoy, might be designated the responsible operator, I note that the Benefits Review Board ("BRB" and "Board") has concluded that 20 C.F.R. § 725.495(a), which provides that the president, secretary, and treasurer of an uninsured employer shall be jointly liable for the payment of any benefits, "cannot be used to modify the definition of responsible operator to include corporate officers." *Lester v. Mack Coal Co.*, 21 B.L.R. 1-126 (1999) (en banc on recon.). In other words, that particular regulatory provision does not draw corporation officers into the process for determining the responsible operator. Instead, DOL may take enforcement action against such individuals under 20 C.F.R. § 725.495(a) which makes certain corporate officers who failed to maintain insurance policies jointly liable for the black lung benefits owed by the uninsured corporation. However, in the Board's opinion, the purpose of this section is not to impose liability on the corporate officers as responsible operators. Instead, it is within the sole discretion of the Director whether to hold certain officers personally liable for debts of an uninsured corporation.[7] I also note that correspondence addressed to Mr. McCoy has been returned as undeliverable for a few years. Primarily in light of the Board's position on the issue, and his unavailability, I find Mr. McCoy and the other corporate offices of Mate Creek do not establish Mate Creek's ability to pay black lung disability benefits in this case.

Consequently, since Mate Creek is not a viable financial entity, the former coal mine company does not meet the requirements for responsible operator.

Maben Energy/East Gulf

Since Mr. F. mined coal about 16 sixteen years for Maben Energy/East Gulf, the first responsible operator criterion is established.

[7]Based on its interpretation of the regulation, the BRB concluded that an administrative law judge may not require the pursuit of, and then adjudicate corporate officer liability of, an uninsured responsible operator.

Once again, however, as self-insured coal mine operators, Maben Energy/East Gulf no longer have the ability to pay continuing black lung disability payments due to bankruptcy proceedings begun in 1997. Similarly, based on *Lester*, and his apparent unavailability, I conclude that Mr. Paul Kizer cannot assume the companies' responsible operator obligations for continuing black lung disability benefits payments. Consequently, due to financial insolvency, Maben Energy/East Gulf are not suitable responsible operators.

Westmoreland

Since neither Mate Creek nor Maben Energy/East Gulf are viable responsible operators, I move to consideration of Westmoreland. Mr. F. worked more than one year as a coal miner for Westmoreland. As a present on-going coal mining company, Westmoreland also remains capable as a self-insured operator to meet its obligation for the payment of ongoing black lung disability benefits. As a result, Westmoreland is the most recent coal mine operator to meet both relevant criteria under 20 C.F.R. §§ 725.492 and 725.493.

Conclusion

Due to their financial dissolution and the absence of insurance, Mate Creek and Maben Energy/East Gulf do not meet all the requirements for responsible operator. Accordingly, I find Westmoreland is the properly designated responsible operator for Mr. F.'s claim.[8]

Issue # 2 – Material Change in Conditions

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. § 725.309, as interpreted by the Benefits Review Board and federal courts of appeals. Under this regulatory provision, according to the U.S. Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-998 (6th Cir. 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider

[8]In a footnote, Employer's counsel cited *Henley v. Cowin & Co.,* BRB No. 05-0788 BLA, slip op. at 3-4 (May 30, 2006) (unpub.), for the proposition that dismissal of Westmoreland as the responsible operator in Mr. F.'s case would require the exclusion of all the medical evidence submitted by the Employer. I note that Benefit Review Board's decision in *Henley* was predicated on the fact the claim was adjudicated under the new evidentiary regulations which does not permit the admission of evidence that was not submit by the viable participants in the proceeding. However, due to filing date, Mr. F.'s claim falls under the old regulations and thus *Henley* is inapplicable. Additionally, in "old" regulations cases, evidence from a dismissed responsible operator may remain in the record. *See York v. Benefits Review Board,* 819 F. 134 (6th Cir. 1987).

> whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997), put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In determining whether there has been a material change in condition, I focus on the four basic conditions, or elements, a claimant must prove by a preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[9] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[10] Third, the miner has to demonstrate he is totally disabled.[11] And fourth, the miner must prove the total disability is due to pneumoconiosis.[12]

With those four principal conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principal conditions of entitlement, the only elements that are capable of changing are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

Mr. F.'s prior claim was finally denied in January 1998 for failure to prove pneumoconiosis. Consequently, for purposes of adjudicating the present duplicate claim, I will evaluate the evidence developed since the denial of his first claim to determine whether Mr. F. can now prove that he has pneumoconiosis.

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[9]20 C.F.R. § 718.202 (2001). Unlike many sections of Part 725, the provisions of Part 718 of the new regulations are applicable to pending claims.

[10]20 C.F.R. § 718.203(a) (2001).

[11]20 C.F.R. § 718.204(b) (2001).

[12]20 C.F.R. § 718.204(a) (2001).

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[13] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic restrictive or obstructive lung disease" that arises "out of coal mine employment."[14] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[15] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202 (2001), the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1) (2001), autopsy or biopsy report (§ 718.202 (a)(2) (2001)), regulatory presumption (§ 718.202(a)(3) (2001)),[16] and medical opinion (§ 718.202(a)(4) (2001)). Since the new evidentiary record does not contain evidence that Mr. F. has complicated pneumoconiosis, and he filed his initial claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report. As a result, Mr. F. will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. Additionally, since Mr. F. last mined coal in West Virginia, according to the court in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), in determining whether Mr. F. has pneumoconiosis, I must consider all the medical evidence together.

Chest X-Rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
October 15, 1984	DX 79	Dr. Alexander, BCR, B[17]	Positive for pneumoconiosis, profusion category 1/0,[18] type p opacities.[19]

[13]20 C.F.R. § 718.201(a) (2001).

[14]20 C.F.R. §§ 718.201(a)(1) and (2) (2001).

[15] 20 C.F.R. § 718.201(b) (2001).

[16]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3) (2001), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (2001) (a presumption when a survivor files a claim prior to June 30, 1982).

[17]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202(a)(1)(ii).

(same)	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis.
January 16, 1985	DX 79	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type s opacities.
(same)	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema present.
February 10, 1997	DX 79	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities.
(same)	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema present.
September 5, 1997	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Spitz, BCR, B	Negative for pneumoconiosis.
October 20, 1999	DX 80	Dr. Spagnolo	Negative for pneumoconiosis; bullous emphysema present.
(same)	DX 79	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities. Mild obstructive pulmonary disease present.
(same)	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema.
November 17, 1999	DX 12	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion category 1/2, type s opacities. COPD (chronic obstructive pulmonary disease) and emphysema present.
(same)	DX 79	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/2, type p/s opacities. Specifically, no emphysema present.
(same)	DX 13 & DX 37	Dr. Navani, B, BCR	Completely negative

[18]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102(b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[19]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	DX 14	Dr. Gaziano, BCR	Positive for pneumoconiosis, profusion category 1/0, type t/s opacities.
(same)	DX 80	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 80	Dr. Scott, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Wiot, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Spitz, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema present.
August 2, 2000	DX 21	Dr. Zaldivar, B	Negative for pneumoconiosis; bullous emphysema present.
(same)	DX 38	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 38	Dr. Scott, BCR, B	Negative for pneumoconiosis.
(same)	DX 39	Dr. Wiot, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 39	Dr. Spitz, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 40	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 80	Dr. Spagnolo	Negative for pneumoconiosis; bullous emphysema present.
(same)	DX 80	Dr. Kim, BCR, B	Negative for pneumoconiosis.
February 21, 2001	DX 41 & DX 80	Dr. Castle, B	Negative for pneumoconiosis; profusion category 0/1, type s opacities.
(same)	DX 43	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 43	Dr. Scott, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 44	Dr .Kim, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 45	Dr. Meyer, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 45	Dr. Spitz, BCR, B	Negative for pneumoconiosis; emphysema present.

Of the 8 chest x-rays in the record, there is no dispute regarding 3 of the films. Based on undisputed consensus of the physicians who reviewed the films, the chest x-rays from September 5, 1997, August 2, 2000, and February 21, 2001 are negative for pneumoconiosis.

The remaining 5 radiographic studies generated a dispute among the physicians who reviewed them. In the October 15, 1984, Dr. Alexander, a dual qualified radiologist, observed the presence of pneumoconiosis. Dr. Wiot and Dr. Meyer, also dual qualified radiologists, disagreed and considered the study to be negative. The consensus of Dr. Wiot and Dr. Meyer represents the preponderance of the medical opinions. As a result, the October 15, 1984 chest x-ray is negative for pneumoconiosis.

The radiographic interpretation dispute between Dr. Alexander, Dr. Wiot, and Dr. Meyer continued with the January 16, 1985, February 10, 1997, and October 20, 1999 chest x-rays. studies. Again, I find the agreement between Dr. Wiot and Dr. Meyer that the films are negative

outweighs Dr. Alexander's contrary assessment.[20] As a result, the January 16, 1985, February 10, 1997 and October 20, 1999 chest x-rays are negative for pneumoconiosis.

Finally, Dr. Patel, an dual qualified radiologist, joined Dr. Alexander in finding the November 17, 1999 chest x-ray positive for pneumoconiosis. However, eight other similarly well qualified radiologists, Dr. Navani, Dr. Gaziano, Dr. Wheeler, Dr. Scott, Dr. Scatarige, Dr. Wiot, Dr. Spitz, and Dr. Meyer, concluded that the chest x-ray was negative. Based on this later overwhelming preponderance of interpretations, I conclude the November 17, 1999 radiographic study is negative for pneumoconiosis.

In summary, all of Mr. F.'s chest x-rays are negative for pneumoconiosis. Accordingly, Mr. F. is unable to establish the presence of pneumoconiosis in his lungs through radiographic evidence under 20 C.F.R. § 718.202(a)(1) (2001).

Medical Opinion[21]

Although Mr. F. cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202(a)(4) (2001) through the preponderance of probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the record is helpful.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[22] post[23]**	**FVC pre post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[24] pre post**	**Comments**
DX 11	Nov. 17, 1999 Dr. Rasmussen	59 65"	2.7	4.95	103	54%	No[25]	Slight obstruction
DX 21	Aug. 2, 2000	60	2.82	5.24	100	54%	No[26]	Moderate,

[20]While Dr. Spagnolo also considered the October 20, 1999 chest x-ray to be negative, he is neither a board certified radiologist nor a B reader. As a result, his interpretation is less persuasive than the opinions of Dr. Alexander, Dr. Wiot and Dr. Spitz.

[21]I have only included the pulmonary medical assessments.

[22]Test result before administration of a bronchodilator.

[23]Test result following administration of a bronchodilator.

[24]Under 20 C.F.R. § 718.204 (b)(2)(i) (2001), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[25]The qualifying FEV_1 number is 1.67 for age 59 and 65."

[26]The qualifying FEV_1 number is 1.65 for age 60 and 65."

	Dr. Zaldivar	65"	2.74	4.99		55%	No	irreversible obstruction
DX 80	Aug. 24, 2000 Dr. Rasmussen	60 64"	2.63 2.64	5.08 4.97	110	52% 53%	No[27] No	Slight obstruction
DX 41	Feb. 21, 2001 Dr. Castle	61 64"	2.39 2.42	4.57 5.43	---	52% 45%	No[28] No	Mild to moderate obstruction

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**$_pCO_2$ (rest) $_pCO_2$ (exercise)**	**$_pO_2$ (rest) $_pO_2$ (exercise)**	**Qualified**	**Comments**
DX 9	Nov. 17, 1999 Dr. Rasmussen	36 37	70 58	No[29] Yes[30]	
DX 21	Aug. 2, 2000 Dr. Zaldivar	34 38	76 69	No[31] No[32]	
DX 41	Feb. 21, 2001 Dr. Castle	37	70	No	

Dr. D. L. Rasmussen
(DX 9 to DX 12, DX 77, DX 78, DX 80, and CX 1)

On November 17, 1999, Dr. Rasmussen, board certified in internal medicine, conducted a pulmonary evaluation. Mr. F. had over 30 years of coal mine employment. In his last job as a mine foreman, Mr. F. engaged in heavy manual labor lifting 50 pound rock dust bags and clearing coal from belt lines. Since 1965, he smoked one-half to one pack of cigarettes a day. For the last several years, Mr. F. experienced chronic shortness of breath and cough.

Upon physical examination, Dr. Rasmussen noted diminished breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a slight obstructive impairment. Although Mr. F. experienced only mild hypoxia at rest, upon exercise, his oxygen transfer capacity was markedly impaired. Based on Mr. F.'s coal mine employment and the chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Dr. Rasmussen diagnosed chronic bronchitis and a respiratory impairment attributed to Mr. F.'s pulmonary risk factors of cigarette smoke and coal mine dust, with the latter exposure being more significant. Due to his marked oxygenation transfer impairment, in part attributable to his exposure to coal mine dust, Mr. F. was totally disabled.

[27]The qualifying FEV_1 number is 1.56 for age 60 and 64."

[28]The qualifying FEV_1 number is 1.54 for age 61 and 64."

[29]For a pCO^2 of 36, the qualifying pO^2 is 64 or less.

[30]For a pCO^2 of 37, the qualifying pO^2 is 63 or less.

[31]For a pCO^2 of 34, the qualifying pO^2 is 66 or less.

[32]For a pCO^2 of 38, the qualifying pO^2 is 62 or less.

On September 29, 2003, upon reviewing Mr. F.'s additional medical record, negative x-ray interpretations, and pulmonary assessments by Dr. Zaldivar, Dr. Rosenberg, and Dr. Castle, Dr. Rasmussen remained convinced that Mr. F. had coal workers' pneumoconiosis and that coal workers' pneumoconiosis was a major cause of his disabling chronic lung disease. Although all the physicians agree that Mr. F. is totally disabled due to a chronic lung disease, they disagree on its cause. While Dr. Zaldivar, Dr. Rosenberg, and Dr. Castle dismiss Mr. F.'s 31 years of coal mine employment, Dr. Rasmussen notes Mr. F. faced two significant pulmonary risk factors: cigarette smoking and coal mine dust. According to Dr. Rasmussen, multiple medical studies establish that cigarette smoke and coal mine dust can cause obstructive pulmonary disease and emphysema. He also noted that pathology findings have linked irregular pulmonary opacities to coal workers' pneumoconiosis. Additionally, the combination of no significant impairment of pulmonary function and significant oxygen transfer deficiency is common among coal miners.

About a year later, on September 27, 2004, Dr. Rasmussen reviewed two more pulmonary assessments by Dr. Branscomb and Dr. Spagnolo. He observed that Dr. Branscomb, Dr. Spagnolo, Dr. Rosenberg, Dr. Castle, and Dr. Zaldivar did not believe pneumoconiosis was a contributing cause of Mr. F.'s pulmonary obstruction due to the absence of radiographic evidence of pneumoconiosis. Based on medical studies and his own 40 years of experience, Dr. Rasmussen disagrees with that consensus and asserts that coal mine dust can cause chronic obstructive disease. He notes that the mechanism by which coal mine dust cause emphysema is shared by cigarette smoking. Clearly, Mr. F. is totally disabled due to blood gas exchange impairment. Although Dr. Rasmussen's own studies have not been published, he has observed the pattern of a blood gas impairment with little pulmonary function loss in many coal miners. Both coal mine dust and cigarette smoke cause small airways disease. Consequently, Dr. Rasmussen continues to see a connection between Mr. F.'s disabling chronic lung disease and his coal mine dust exposure.

On April 19, 2006, Dr. Rasmussen responded to Dr. Fino's medical record review by discussing numerous medical studies that were both supportive and unsupportive of Dr. Rasmussen's conclusion that Mr. F.'s coal mine dust exposure contributed to his obstructive pulmonary impairment. Based his understanding of the medical studies, and asserting that the mechanisms by which coal mine dust and cigarette smoke damage lung tissue are identical, Dr. Rasmussen questioned Dr. Fino's statement that coal mine dust is not associated with the development of bullous emphysema. While agreeing with Dr. Fino's diagnosis of emphysema, Dr. Rasmussen disagrees with Dr. Fino's "dismissal" of coal mine dust as contributing factor. In Dr. Rasmussen's opinion, Mr. F.'s long term exposure to coal mine dust "is at least as significant and likely to cause disabling chronic obstructive pulmonary disease as cigarette smoking." Consequently, Mr. F. has coal mine dust-induced COPD.

Dr. George L. Zaldivar
(DX 21 and DX 80)

On August 2, 2000, Dr. Zaldivar, board certified in pulmonary and internal medicine and critical care, conducted a pulmonary examination. Mr. F. had 31 years of coal mine employment. He last mined coal in 1999 as a mine foreman which required him to do nearly every job in the coal mine, including cleaning coal belts. Mr. F. has smoked cigarettes since he

was 26, usually one pack a day. Recently, he reduced his smoking to half a pack a day. Mr. F. reported shortness of breath for the past 15 years.

Upon physical examination, the chest was normal. The chest x-ray was negative for pneumoconiosis. The arterial blood gas study did not reach total disability thresholds. The pulmonary function test indicated the presence of a moderate irreversible airways obstruction. Based on his examination, Dr. Zaldivar concluded Mr. F. did not have coal workers' pneumoconiosis. Mr. F. was totally disabled for heavy manual labor due to the airways obstruction which was caused by cigarette-smoking induced bullous emphysema. Coal workers' pneumoconiosis does not cause bullous emphysema.

In a September 22, 2003 deposition, Dr. Zaldivar reviewed his pulmonary examination of Mr. F. By history, Mr. F. faced two significant pulmonary risk factors, cigarette smoking and coal mine dust. The chest x-ray was negative for coal workers' pneumoconiosis and indicated the presence of bullous emphysema. Typically, coal workers' pneumoconiosis does not cause bullous emphysema unless it has developed into progressive massive fibrosis. In that event, bullous emphysema may develop around the large pneumoconiosis mass. Mr. F.'s pulmonary function test was somewhat unusual. While some of the key values were normal, the ratio of the values and reduced diffusion demonstrated that he had a moderate impairment. The reduced diffusion occurs when the capillaries restrict due to cigarette smoking cause diminished blood supply. During exercise, Mr. F.'s blood oxygenation also deteriorated. In Dr. Zaldivar's opinion, Mr. F. is unable to perform heavy manual labor. Dr. Zaldivar also reviewed other pulmonary assessments and determined the additional medical tests supported his conclusion that Mr. F. does not have coal workers' pneumoconiosis. Usually, when pneumoconiosis causes a pulmonary obstruction, radiographic evidence of extensive dust deposition is present. However, Dr. Zaldivar bases his conclusion that Mr. F. not have coal workers' pneumoconiosis or a pulmonary impairment due to coal mine dust exposure on all the objective medical evidence.

On August 30, 2004, Dr. Zaldivar reviewed additional medical records. He noted Mr. F. had decreased diffusion with airway obstruction and air trapping, compatible with emphysema. After raising numerous issues with the medical studies relied upon by Dr. Rasmussen, Dr. Zaldivar cited numerous medical studies linking the fibrosis noted Mr. F.'s lungs with cigarettes smoking. Essentially, coal mine dust causes emphysema when it causes extensive lung damage. Dr. Zaldivar found insufficient objective medical evidence to support a diagnosis of coal workers' pneumoconiosis. Due to his mild to moderate pulmonary impairment, Mr. F. is unable to perform heavy labor. His pulmonary impairment is due to cigarettes and unrelated to exposure to coal mine dust. Even if biopsy evidence established the presence of pneumoconiosis, Dr. Zaldivar opines that would not be the cause of Mr. F.'s impairment. Mr. F. has neither clinical nor legal pneumoconiosis.

Dr. James R. Castle
(DX 41 and DX 80)

On February 21, 2001, Dr. Castle, board certified in pulmonary disease and internal medicine, examined Mr. F. A former miner with 31 years of coal mine employment, Mr. F. complained about chronic shortness of breath with exertion. Mr. F. stopped mining coal after he

suffered a neck injury. Currently smoking half a pack of cigarettes a day, Mr. F. had a 17 pack-year[33] history.

Upon physical examination, Dr. Castle heard normal breath sounds. The chest x-ray was negative for pneumoconiosis and the arterial blood gas study was normal. The pulmonary function tests revealed a mild to moderate airways obstruction. Dr. Castle concluded Mr. F. did not have coal workers' pneumoconiosis. Instead, Mr. F. struggled with COPD (chronic obstructive pulmonary disease) and emphysema attributable to his tobacco use. His moderate airways obstruction precluded a return to heavy manual labor and coal mine employment. Mr. F.'s pulmonary disability was related solely to his cigarette smoking.

As part of his assessment, Dr. Castle also reviewed the additional radiographic evidence and the examination reports of Dr. Rasmussen and Dr. Zaldivar. Dr. Castle noted the preponderance of the radiographic evidence was negative for pneumoconiosis. Additionally, even if coal workers' pneumoconiosis were present in the films, Mr. F. did not have any physiologic abnormalities consistent with coal workers pneumoconiosis.

In a September 9, 2003 deposition, Dr. Castle further explained his assessment of Mr. F.'s pulmonary condition. Initially, Dr. Castle observed that Mr. F.'s physical examination was "unremarkable." The chest x-ray was negative for coal workers' pneumoconiosis. The pulmonary function study showed a mild to moderate pulmonary obstruction with air trapping, consistent with tobacco smoke-induced bullous emphysema, as seen in the chest x-rays. Dr. Castle is unaware of any medical study showing a connection between coal mine dust exposure and bullous emphysema. Dr. Castle explained that bullous emphysema is large dilated air spaces which causes a loss of lung surface for oxygen transfer. As demonstrated by his arterial blood gas studies, Mr. F. has the expected oxygen transfer deficiency due to bullous emphysema. Mr. F. is totally disabled due to bullous emphysema. He does not have clinical or legal coal workers' pneumoconiosis.

On September 10, 2004, Dr. Castle reviewed additional chest x-ray interpretations and pulmonary assessments by Dr. Branscomb, Dr. Spagnolo, Dr. Rosenberg, and Dr. Rasmussen. In light of this additional review, Dr. Castle observed that the preponderance of the radiographic evidence remained negative for pneumoconiosis. Additionally, several aspects of the pulmonary tests, including gas trapping, hyperinflation, and moderate reduction of diffusion capacity were consistent with tobacco smoking induced bullous emphysema, which was also appeared in the chest x-ray, rather than coal workers' pneumoconiosis. Similarly, Mr. F.'s exercise hypoxemia was consistent with emphysema associated with cigarette smoking. Consequently, Dr. Castle concluded Mr. F.'s totally disabling pulmonary impairment is due to his 36 years of cigarette smoking.

Dr. David M. Rosenberg
(DX 80)

On May 28, 2003, Dr. Rosenberg, board certified in pulmonary disease, internal medicine and occupational disease, conducted a medical record review of Mr. F.'s pulmonary condition. Mr. F. had 31 years of coal mine employment and smoked 1/2 to 1 pack of cigarettes a day for

[33]A pack-year equals the consumption of a pack of cigarettes a day for one year.

more than 30 years. Mr. F.'s chest x-rays did not show the micronodularity associated with coal mine dust which usually begins in the upper lung fields. Instead, the pulmonary function tests showed air trapping consistent with emphysema. Likewise, the combination of Mr. F.'s oxygenation transfer impairment, pulmonary air trapping and radiographic findings are "readily explained" by his cigarette smoking. Coal mine dust causes COPD by developing and then worsening as focal emphysema. Mr. F.'s chest x-rays do not show such advanced nodularity. As a result, Dr. Rosenberg believes it is unlikely that Mr. F.'s diffusion deficiency and oxygenation transfer shortfall relate to his inhalation of coal mine dust. Mr. F. does not have coal workers' pneumoconiosis or an impairment attributable to coal mine dust exposure.

In an October 4, 2004 deposition, Dr. Rosenberg discussed his assessment of Mr. F.'s pulmonary condition. Dr. Rosenberg reached his conclusion after reviewing the pulmonary assessments and radiographic evidence from 1997 to 2004, including Dr. Rasmussen's September 2004 pulmonary evaluation. Preliminarily, Dr. Rosenberg noted Mr. F.'s long history as a coal miner which required medium physical labor and his significant cigarette smoking history. The preponderance of the chest x-rays did not disclose any coal mine dust-induced lung disease. The type of noted opacities and their location were inconsistent with pneumoconiosis, which presents as rounded opacities in the upper lung zones. Instead, the linear opacities noted Mr. F.'s lungs were consistent with aging and cigarette smoking. Concerning Dr. Rasmussen's reliance on one medical study, Dr. Rosenberg questioned its validity since the study was uncontrolled.

Mr. F.'s pulmonary function test was essentially normal. Likewise, the resting blood gas study showed only mild hypoxemia. However, upon exercise, Mr. F. developed a significant oxygenation insufficiency. Dr. Rosenberg does not attribute the oxygenation impairment to Mr. F.'s long term exposure to coal mine dust because that type of impairment develops only if coal workers' pneumoconiosis macules and micronodules are extensive and identifiable by chest x-ray and low diffusion in the pulmonary function test. Dr. Rosenberg also doesn't believe emphysema is the cause of the problem. Instead, Dr. Rosenberg diagnoses Mr. F.'s pulmonary problem as idiopathic pulmonary fibrosis.

In his opinion, Mr. F. does not have either clinical or legal coal workers' pneumoconiosis. Mr. F.'s is totally disabled due to idiopathic pulmonary fibrosis. Dr. Rosenberg acknowledged that pathological evidence of pneumoconiosis may exist when the chest x-ray evidence is negative for its presence. However, to conclude coal workers' pneumoconiosis contributed to his impairment, Dr. Rosenberg would require a chest x-ray positive for coal workers' pneumoconiosis. In his opinion, coal mine dust cannot be a contributing cause of an obstructive impairment unless there are chest x-ray changes consistent with coal workers' pneumoconiosis.

Dr. Samuel V. Spagnolo
(DX 80)

On May 24, 2003, Dr. Spagnolo, board certified in pulmonary disease and internal medicine, reviewed Mr. F.'s medical record. After 31 years of coal mine employment, Mr. F. engaged in heavy labor in his last job as a mine foreman. Mr. F.'s cigarette smoking history was

17 pack-years. Although Mr. F. had significant exposure to coal mine dust, based on the physical presentation, pulmonary tests, and radiographic evidence, Dr. Spagnolo concluded Mr. F. did not have any pulmonary disease attributable to his coal mine employment. The preponderance of the chest x-rays were negative for pneumoconiosis and showed hyperinflation associated with bullous emphysema. Based on the chest x-rays and pulmonary test results, Dr. Spagnolo attributes Mr. F.'s pulmonary problems to his long term cigarette smoking history. Mr. F.'s slightly reduced oxygen transfer capacity precludes his return to work requiring heavy labor. Mr. F. does not have coal workers' pneumoconiosis. Even if pneumoconiosis were present, it would not alter Dr. Spagnolo's determination that Mr. F. is not totally disabled due to coal workers' pneumoconiosis.

On August 22, 2004, Dr. Spagnolo reviewed additional assessments by Dr. Branscomb, Dr. Rosenberg, and Dr. Rasmussen and negative chest x-ray interpretations. He remained convinced "the totality of the medical findings are consistent with the effects of long-term cigarette smoking."

In an October 6, 2004 deposition, Dr. Spagnolo discussed his review of Mr. F.'s medical record. Mr. F. had 31 years of coal mine employment and smoked one to one-half pack of cigarettes a day since he was 26 years old. Dr. Spagnolo agreed that coal workers' pneumoconiosis can cause an obstructive and restrictive impairment. The physician observed that the preponderance of the radiographic evidence was negative for pneumoconiosis. At the same time, the chest x-rays showed the presence of bullous emphysema, which is most likely due to Mr. F.'s cigarette smoking history. Although coal mine dust can cause focal emphysema, it does not cause bullous emphysema. Mr. F.'s pulmonary function studies, showing a mild to moderate airways obstruction with air trapping, are also consistent with bullous emphysema.

Dr. Ben V. Branscomb
(DX 80)

On May 21, 2003, Dr. Branscomb, board certified in internal medicine, conducted a review of Mr. F.'s medical record. The physician noted Mr. F. worked as a coal miner for 31 years and smoked between half a pack and one pack of cigarettes a day for more than 33 years. The preponderance of the chest x-ray interpretations were negative for pneumoconiosis. The pulmonary function studies were essentially normal with some air trapping. The arterial blood gas studies showed a fall in oxygen transfer with exercise. Based on the combination of these findings, and due to the absence of a productive cough, Dr. Branscomb opined Mr. F. had bullous emphysema, rather than COPD. Bullous emphysema is caused by cigarettes smoking and not associated with exposure to coal mine dust. In terms of disability, since Mr. F. remained working as a coal miner even after Dr. Rasmussen identified the oxygen transfer deficiency, Dr. Branscomb questions whether Mr. F. is totally disabled from coal mine employment. Nevertheless, if Mr. F. had to engage in more than 30 minutes of heavy labor as a mine foreman then Dr. Branscomb would consider him to be totally disabled. The cause of any pulmonary impairment Mr. F. may have is his long term cigarette smoking rather than his lengthy exposure to coal mine dust or coal workers' pneumoconiosis.

Dr. Gregory J. Fino
(EX 3 and EX 4)

On March 3, 2006, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted a review of Mr. F.'s medical record, including numerous pulmonary examinations, pulmonary assessments, and radiographic record. As part of his analysis, Dr. Fino summarized the results of each evaluation and test, which indicated Mr. F. had 31 years of coal mine employment and a cigarette smoking history of at least one half pack of cigarettes a day for over 30 years. Based on his review, Dr. Fino diagnosed COPD due to pulmonary emphysema. Concerning the etiology of Mr. F.'s emphysema, Dr. Fino relied on two key factors. First, the preponderance of the radiographic interpretations established the presence of bullous emphysema or bullae. Additionally, the pattern of Mr. F.'s pulmonary and respiratory tests showing diminished profusion capacity and oxygenation deficiency with exercise are consistent with bullous emphysema. Second, coal workers' pneumoconiosis and coal mine dust do not cause bullous emphysema. Bullae may be associated with pneumoconiosis but only in severe cases involving complicated pneumoconiosis or progressive massive fibrosis, which are not the pulmonary conditions present in Mr. F.'s lungs. Although in certain situations, coal mine dust may cause other types of emphysema, that occurs only when the lungs retain a significant amount of coal mine dust. The radiographic evidence and pulmonary tests demonstrate that Mr. F. does not have high levels of coal mine dust retention in his lungs. Dr. Fino also cited several medical studies supporting his assessment. Consequently, Dr. Fino opines that Mr. F.'s bullous emphysema and associated disabling impairment are due solely to his inhalation of cigarette smoke and were not caused by coal mine dust exposure. Mr. F. is totally disabled due to the cigarette smoking-induced emphysema. Even if Mr. F. were found to have coal workers' pneumoconiosis, it would not have contributed to his respiratory disability.

Discussion

Over the course of several years, the numerous physicians who evaluated Mr. F.'s pulmonary condition disagreed on whether he has coal workers' pneumoconiosis. Dr. Rasmussen concluded Mr. F. has clinical and legal pneumoconiosis. On the other hand, Dr. Zaldivar, Dr. Castle, Dr. Rosenberg, Dr. Spagnolo, Dr. Branscomb, and Dr. Fino determined that Mr. F. did not have either clinical or legal pneumoconiosis.

In light of this conflict in medical opinion concerning the presence of pneumoconiosis, I must assess the respective probative value of these diverse assessments in terms of documentation and reasoning. As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's

reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these two factors in mind, and due to the two types of pneumoconiosis, I will separately address the probative value of the physicians' opinions in terms of clinical and legal pneumoconiosis.

Clinical Pneumoconiosis

To the extent that Dr. Rasmussen ultimately concluded that Mr. F. has clinical pneumoconiosis, his opinion has diminished probative value due to inaccurate documentation. Following his November 17, 1999 pulmonary assessment of Mr. F., Dr. Rasmussen diagnosed clinical coal workers' pneumoconiosis on the basis of Mr. F.'s long term exposure to coal mine dust and a positive chest x-ray interpretation. Yet, based on the preponderance for the interpretations by similarly well qualified physicians, I have subsequently determined that the none of the chest x-rays show the presence of pneumoconiosis. As result, Dr. Rasmussen's diagnosis of clinical pneumoconiosis has little probative weight.

Consistent with the preponderance of the radiographic interpretations, Dr. Zaldivar, Dr. Rosenberg, Dr. Castle, Dr. Spagnolo, Dr. Branscomb, and Dr. Fino presented reasoned opinions based on accurate documentation that Mr. F. does not have clinical pneumoconiosis.

Accordingly, based on the preponderance of the probative medical opinion, I find Mr. F. is unable to prove the presence of clinical pneumoconiosis through medical opinion under 20 C.F.R. § 718.202(a)(4) (2001).

Legal Pneumoconiosis

On the issue of legal pneumoconiosis, I first give Dr. Rosenberg's assessment that Mr. F. pulmonary fibrosis is unrelated to his coal mine employment diminished probative weight due to a legal reasoning shortfall. Although certainly well documented and surely medically sound, Dr. Rosenberg's opinion suffers a legal deficiency because his analysis on the presence of legal pneumoconiosis is essentially identical to his basis for finding that Mr. F. does not have clinical pneumoconiosis. Specifically, after diagnosing Mr. F. with pulmonary fibrosis, and while agreeing that a miner could have a disabling obstructive pulmonary impairment due to coal mine dust exposure, Dr. Rosenberg stated that he could attribute Mr. F.'s fibrosis to his coal mine employment only if the associated chest x-rays showed extensive opacities consistent with coal workers' pneumoconiosis. In other words, although he expresses an understanding of the term "legal pneumoconiosis," his diagnosis of legal pneumoconiosis requires the presence of clinical pneumoconiosis. Again, while that rationale may be medically sound, legal pneumoconiosis as defined by the Benefits Review Board, appellate courts, and 20 C.F.R. § 718.201(a)(2) (2001), contains no such prerequisite. That is, legal pneumoconiosis may be represented by a chronic obstructive lung disease arising out of coal mine employment, even in the absence of

radiographic evidence of pneumoconiosis. Consequently, since Dr. Rosenberg requires the presence of clinical pneumoconiosis before diagnosing legal pneumoconiosis, his opinion loses probative value.

In a documented evaluation, Dr. Spagnolo integrated all the objective medical evidence to reach a reasoned and probative conclusion that Mr. F.'s bullous emphysema is attributable to his cigarette smoking. Noting the radiographic and pulmonary tests supported a finding of bullous emphysema, and agreeing that coal mine dust can cause a pulmonary obstructive impairment, Dr. Spagnolo explained that while exposure to coal mine dust may cause focal emphysema, it does not also produce bullous emphysema.

Based on an extensive review, Dr. Branscomb also diagnosed bullous emphysema. Since he believed coal mine dust does not cause that type of emphysema, the physician presented a reasoned conclusion that Mr. F.'s pulmonary obstruction did not arise out of his coal mine employment.

In an extensively documented assessment, Dr. Castle presented a reasoned explanation for his conclusion that Mr. F.'s emphysema is due solely to his cigarette smoking. In a well integrated analysis, Dr. Castle relied on the combination of radiographic imaging, low diffusion in the pulmonary function tests, and oxygenation deficiency upon exercise to determine that Mr. F. has bullous emphysema. Finding no credible medical studies linking that type of emphysema to coal dust exposure and noting that bullous emphysema is typical for cigarette smokers, Dr. Castle's conclusion that Mr. F. does not have an obstructive impairment due to cigarette smoking has significant probative value.

Dr. Zaldivar also conducted a well documented analysis and reached a reasoned, probative conclusion that Mr. F.'s bullous emphysema is not related to his exposure to coal mine dust. While recognizing that in some severe cases of coal workers' pneumoconiosis, such as progressive massive fibrosis, bullous emphysema may develop, and noting that Mr. F.'s radiographic evidence was negative for pneumoconiosis, Dr. Zaldivar emphasized that he reached his etiology determination based on all the objective medical tests, including the low diffusion test results which occurs due to cigarette smoke-induced pulmonary capillary restriction. Dr. Zaldivar also relied on medical studies which establish that cigarette smoking causes bullous emphysema.

After completing an extensive summarization of Mr. F.'s medical record and pulmonary examinations, Dr. Fino presented a well reasoned assessment on the effect Mr. F.'s two pulmonary risk factors, cigarette smoking and coal mine employment, may have had on his pulmonary obstruction. The radiographic evidence, coupled with the pattern of the results from Mr. F.'s pulmonary and respiratory tests, establish that Mr. F. has bullous emphysema. Severe cases of pneumoconiosis, such as complicated pneumoconiosis, may cause bullae or bullous emphysema. However, all the objective medical evidence demonstrates that Mr. F. does not have that high level of coal dust retention in his lungs. As a result, in light of the objective medical evidence and considering several medical studies, Dr. Fino reached a probative opinion that Mr. F.'s bullous emphysema is due solely to his cigarette smoking.

In summary, after setting aside Dr. Rosenberg's medically sound, but legally flawed, opinion on the presence of legal pneumoconiosis, the remaining opinions are documented, reasoned, and probative. Relying the same objective medical evidence, agreeing Mr. F. has bullous emphysema, and at times citing different and seemingly conflicting medical studies, the other similarly well qualified physicians reached starkly different conclusions about the cause of Mr. F.'s pulmonary obstructive impairment. In a probative opinion, Dr. Rasmussen concluded Mr. F.'s coal mine dust exposure was a significant contributing factor in his development of bullous emphysema. However, in probative assessments, Dr. Spagnolo, Dr. Branscomb, Zaldivar, Dr. Castle, and Dr. Fino reached a different conclusion and determined coal mine dust did not cause Mr. F.'s bullous emphysema. On balance, the consensus of the latter five physicians represents the preponderance of the probative medical opinion and establishes that Mr. F. does not have legal pneumoconiosis. Accordingly, based on the preponderance of the probative medical opinion, I find Mr. F. is unable to prove the presence of legal pneumoconiosis through medical opinion under 20 C.F.R. § 718.202(a)(4) (2001).

Compton Analysis

Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must also consider the chest x-ray evidence and medical opinion together to determine whether Mr. F. has pneumoconiosis. In that regard, since standing alone neither the preponderance of the chest x-rays nor the preponderance of the medical opinion established the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

Conclusion

Upon consideration of the entire record associated with his second claim, I find the preponderance of the radiographic evidence is negative for pneumoconiosis. Similarly, the preponderance of the probative medical opinion demonstrates that Mr. F. does not have either clinical or legal pneumoconiosis. As a result, Mr. F. has failed to prove the presence of pneumoconiosis in his lungs and a material change in condition since the denial of his prior claim. Accordingly, under 20 C.F.R. § 725.309(d), his present, duplicate claim for benefits under the Act must be denied.

ORDER

The black lung disability benefits claim of MR. J.E.F. is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: June 12, 2007
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).